Iowa Department of Human Services

Iowa State Innovation Model (SIM)
Long Term Care Integration Workgroup
Summary of Suggestions and Discussions

The recommendations included reflect the work of the Long Term Care Integration Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

October 2013

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Executive Summary

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

In order to ensure attention and feedback on the key strategies outlined in the original grant proposal and to support the State in developing a framework for the Accountable Care Organization (ACO) model, the State developed four workgroups, one for each key strategy. These workgroups are: Metrics and Contracting; Behavioral Health Integration; Long Term Care Supports and Services Integration; and Member Engagement. All workgroup meetings were open to the public and agendas and minutes were posted to the DHS website, as were other supporting resources.

Each workgroup met four times for two hours, over the course of two months. The first meeting was primarily focused on providing information to workgroup members about the project, the context and their roles. The next three meetings were focused on discussing and developing recommendations for transforming Iowa's health care system that would be considered for inclusion in state's SHIP.

This report provides a summary of the original reference report provided to the Long Term Care Integration Workgroup, and details about questions that were discussed in the meetings. Additionally, recommendations and suggestions generated by the Workgroup members and meeting attendees are included in this report.

Overview of Approach

The State of Iowa has been developing a State Health Care Innovation (SHIP) - the multi-year plan that ensures the State achieves its goals of lowering health care costs, improving the quality of health care for Iowans, and improving health outcomes for Iowans. Stakeholder engagement and involvement are core tenets of the State Innovation Model (SIM) grant that the State received from the Centers for Medicare and Medicaid Innovation and the State has undertaken an extensive and comprehensive approach to involving all stakeholders in the SIM design process.

In order to ensure attention and feedback on the key strategies outlined in the original grant proposal and to support the State in developing a framework for the Accountable Care Organization (ACO) model, the State developed four workgroups, one for each key strategy.

These workgroups are:

- *Metrics & Contracting*: Chaired by Tom Evans, this workgroup was tasked with developing recommendations and goals around the structural arrangement of the ACOs, payment provisions and metrics and measures to use.
- *Behavioral Health Integration:* Chaired by Rick Schults, this workgroup discussed measures that should be used to ensure accountability for behavioral health care needs, considerations for including the safety net providers in any ACO arrangement and the importance of building upon the strengths of the Integrated Health Home and the current Iowa Plan and its additional services and focus on recovery.
- *Long-term Care Supports and Services Integration*: Chaired by Donna Harvey, this workgroup focused on the best approach to integrating these important services into the ACO model, what care coordination should look like and what types of measures will encourage and support increased use of home and community based services.
- *Member Engagement*: Chaired by Chris Atchinson, this workgroup was tasked with developing goals and recommendations about approaches to engaging members in their own care and encouraging them to be active participants in becoming healthier. There was also discussion about how to include and incorporate the strengths of the public health system in order to address population health and achieve the Governor's Healthiest State Initiative.

Each workgroup met four times for two hours. The meetings were held every other week during the weeks of: July 22, August 5, August 19 and September 2. All workgroups had appointees but were open to the public. Meeting materials were posted on the IME SIM website, including reading materials for work group members to read before meetings, meeting agendas and meeting minutes. Although the specific areas of focus differed, the workgroup meetings were arranged as follows:

- Workgroup meeting #1: Level setting with a focus on the entire project, the need for transformation, an introduction to the ACO concept, an overview of the regional approach which will be part of the ACO model, and use of a competitive procurement process which will included multiple steps, including a Request for Information and Request for Proposals

- Workgroup meeting #2: Analysis and discussion of what works in the system of focus (LTC, BH, etc.), what does not work, and the goals and visions for a transformed system. From these workgroups, four summary documents of the key themes identified in each workgroup were developed.
- Workgroup meeting #3: Focus on developing 10 to 12 recommendations. These recommendations were then sent to the workgroups for them to identify and select their priorities. They were also asked to provide additional recommendations which might not have been mentioned. These priorities were then compiled into a summary document and shared prior to the fourth workgroup.
- Workgroup meeting #4: Focus on discussing and refining the recommendations, and soliciting any additional recommendations. Members were also asked to comment on priorities and discuss whether they would shift any of the priorities after further thought.

Prior to the first meeting, the SIM team developed a reference report for each workgroup. The Long Term Care Integration paper provides an overview of the current state of Long Term Care Supports and Services (LTCSS) in Iowa, the preferred future state, key considerations based on lessons learned from other states, and examples of approach other states are using. At the end of the reference report there were a series of questions that guided the discussions during workgroup meetings 2, 3 and 4.

Report Purpose

This LTCSS Integration Workgroup report summarizes the original reference report as well as the workgroup discussions and suggestions. The recommendations included reflect the work of the long Term Care Integration Workgroup and may not reflect the position of the Governor's Office and the Department of Human Services.

Overarching Principles and Goal

The Accountable Care Organization model provides an opportunity to transform Iowa Medicaid into a patient-centered system that provides more coordinated and integrated care, improves the patient experience of care, achieves better health outcomes, and reduces cost by coordinating care, providing services in the right place at the right time and reducing rates of inappropriate utilization (for example, non-emergent use of emergency rooms and avoidable hospital readmissions). IME's overall vision is to implement a multi-payer ACO methodology across Iowa's primary health care payers.

Medicaid is the primary payer for LTCSS. As such, the State has sufficient leverage to influence delivery system change. The success of an ACO model in Medicaid will be determined by the State's success in being able to integrate care for the highest cost/highest risk populations with very intense needs for social and community-based supports. Moreover, the inclusion of long-term care services and supports (LTCSS) into the ACO value-based framework will reduce duplication of effort and increase use of home and community-based services, thereby lowering use of more costly institutional services and allow beneficiaries to remain in their homes and communities.

In developing the ACO model, the State's goals are to:

- Shift utilization from institutional care to Home and Community Based Services (HCBS);
- Use existing initiatives, such as the Balancing Incentives Payment Program (BIPP) to facilitate transformation of the LTCSS to one that includes BIPP required components such as: (1) no wrong door/single point of entry; (2) conflict free case management; (3) use of a core standardized assessment instrument: and
- Have a well-developed stakeholder engagement process throughout all phases, including planning, design, development, implementation and on-going monitoring.

Current ("As Is") State

The vast majority of long-term care supports and services (LTCSS) in the State are provided by Medicaid. These populations particularly suffer from fragmented delivery systems of care which can result in poor outcomes. In addition, these services are expensive; of the total Medicaid budget, long term care expenditures account for more than half of all expenditures.

The system includes both institutional and community-based services. As of December 2012, there were just under 12,000 people in nursing facilities and there were more than 25,000 enrolled in one of the following home and community-based waiver (HCBS):

- AIDS
- Brain Injury
- Children's Mental Health
- Elderly
- Ill and Handicapped
- Intellectually Disabled
- Physical Disability

Services vary by waiver but everyone received service coordination and a comprehensive service plan. Some of the waivers – Brain Injury, Children's Mental Health, Ill and Handicapped, and Physical Disability – have waitlists.

Approximately 53 percent of all LTCSS expenditures are for institutional care, a rate which was several percentage points higher just a few years ago. The State is proud of its transition to greater use of home and community-based services and recently received a Balancing Incentive Payment Program (BIPP) grant. As part of this grant, Iowa will receive an increased federal match of 2 percent for non-institutional community base services, dependent upon the actual amount spent on these services. BIPP grantees are required to implement specific steps to streamline access to services, improve efficiency, consistency and fairness to eligibility determination and assessments and ensure conflict-free case management.

In an effort to reduce hospital admissions and shift utilization from institutional care to HCBS, the Iowa Health Care Collaborative is working with LTC and post-acute care providers to decrease hospital admissions by 15 percent over a 3-year period. One of their objectives is to connect the Aging Disability Resource Centers and other entities to increase coordination.

Future State ("To Be" State)

The State is developing ACOs that will be multi-payer and be modeled after Wellmark's new program for commercially-insured individuals. Wellmark is currently working with health systems across the state and makes payments to the ACOs that are in addition to Fee for Service (FFS) payments. The additional payments and are comprised of a shared savings component and a quality incentive payment. To qualify for any shared savings payment opportunity, certain measures must be equal to or better than the target. Measures that trigger the shared savings opportunity are in the Value Index Scores (VIS). Shared savings are not applicable until year three.

The quality measures are in six domains:

1. Member experience
2. Primary and secondary prevention
3. Tertiary prevention
4. Population health status
5. Continuity of care
6. Chronic and follow-up care

The State will use this value-based framework as the foundation for all services and will expand it to integrate LTCSS. All Medicaid members including Members receiving LTCSS will be enrolled in the ACO program - only those individuals with intellectual disabilities will be excluded initially. It is possible the State will consider phasing-in LTCSS over time. As part of the ACO model, the State will augment the VIS with measures that will support care coordination and a comprehensive whole-person approach to caring for individuals with LTCSS needs and will incentivize greater use of home and community based services in lieu of institutional services.

Key Considerations in Integrating LTCSS

Iowa is not alone in changing the way LTCSS are delivered and in taking steps to integrate these services with acute and behavioral health care services. Most states undergoing this type of transition are choosing to use capitated managed care plans to provide all services. In this way they are moving the delivery of LTCSS from a fee-for-service model that rewards volume of services to one that is more coordinated, rewards high-quality care, encourages the provision of LTCSS in non-institutional settings, and integrates all services. The SIM team is not aware of any states that are integrating services using an ACO model, several, including Oregon and Colorado, are moving in that direction.

In addition to states developing comprehensive managed care programs that cover all benefits, many states are operating or are in the process of developing programs that use capitated managed care plans to provide the LTCSS benefits (but exclude all other benefits). For example, New York's Managed Long-Term Care program provides only the LTCSS within the capitation rate (NY has another program which has comprehensive capitation rates). Over

the past decade, there has been tremendous growth in the use of these managed long term service and supports (MLTSS) programs.[1] According to a recent report prepared for CMS:[2]

- MLTSS grew significantly between 2004 and 2013. The number of states with programs has doubled from 8 to 16 and the number of people receiving MLTSS grew from 105,000 to 389,000. By 2014, the authors of the report project 26 states will have MLTSS.
- Arrangements are diverse. About half the states have mandatory enrollment, seven have voluntary and one has both types.
- Fifteen of the states place contractors at full-risk and 12 offer consumer-directed options.
- States use various methods for obtaining ongoing input from enrollees but nearly all states require contractors to convene member advisory committees.
- Most states have incorporated LTSS-specific measures into their quality management programs, though the lack of a nationally endorsed set of measures has inhibited adoption of measures across states and programs.

Because of this growth, CMS recently provided guidance to states seeking to develop, implement and manage MLTSS programs. While the guidance addresses the more traditional capitated approach and builds off lessons learned from the 16 states that have programs, the other states in the design and implementation phases, and feedback obtained from various consumer organizations the key elements would also apply to Iowa and others (like Colorado and Oregon) moving to an ACO model. Specifically, CMS identified the following elements they believe will increase the likelihood of a high quality MLTSS program. CMS stated they expect states to incorporate these elements into their planning and proposed program designs.[3]

1. **Adequate Planning:** It is essential to allow adequate time in advance of implementing new, expanded or reconfigured MLTSS programs to allow for thoughtful planning and design, incorporation of stakeholder input, and implementation of safeguards to ensure a smooth transition to MLTSS.
2. **Stakeholder Engagement:** Successful programs have developed a structure for engaging stakeholders regularly in the development and implementation of new, expanded or reconfigured MLTSS programs. This includes cross-disability representation of individual participants as well as community, provider, and advocacy groups in order to obtain meaningful input into both the planning and operation of MLTSS programs. CMS will expect states to have a formal process for the ongoing education of stakeholders prior to, during, and after implementation, and states must require their contractors to do the same.
3. **Enhanced Provision of Home and Community Based Services:** All MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision. Under the law, MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation.

[1] CMS defines MLTSS as those that are an "arrangement between State Medicaid programs that make capitated payments to contractors primarily for LTSS and are accountable for the delivery of services and supports that meet quality and other standards set in the contract."

[2] Paul Saucier, Jessica Kasten, Brian Burwell, and Lisa Gold, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update," *Truven Health Analytics,* prepared for CMS, July 2012.

[3] Centers for Medicare and Medicaid Services, "Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs," *Centers for Medicare and Medicaid Services*, May 20, 2013.

4. **Alignment of Payment Structures and Goals:** States must design their payment structures so that they support the goals of their MLTSS programs and the essential elements of MLTSS. Effective programs hold providers accountable through performance-based incentives and/or penalties. On an ongoing basis, states must evaluate their payment structures and make changes necessary to support the goals of their programs.
5. **Support for Beneficiaries:** MLTSS participants must be offered conflict-free education, enrollment/disenrollment assistance, and advocacy in a manner that is accessible, ongoing, and consumer-friendly.
6. **Person-centered Processes:** All MLTSS programs must require and monitor the implementation and use of person-centered needs assessment, service planning, and service coordination policies and protocols. MLTSS programs should encourage participant self-direction and provide opportunities for self-direction of services.
7. **Comprehensive, Integrated Service Package:** MCOs must provide and/or coordinate the provision of all physical and behavioral health services and LTSS (including institutional and non-institutional) and must ensure that participants receive those services and supports in the amount, duration, scope, and manner as identified through the person-centered assessment and service planning process.
8. **Qualified Providers:** States must ensure that MCOs develop and maintain a network of qualified LTSS providers who meet state licensing, credentialing, or certification requirements and which is sufficient to provide adequate access to all services covered under the MCO contract. For states transitioning from Fee for Service (FFS) to MLTSS, states should encourage, or require through contract provisions, the incorporation of existing LTSS providers as MCO network providers to the extent possible. States must provide, or require MCOs to provide, support to traditional LTSS providers, which may include areas such as information technology, billing, and systems operations, to assist them in making the transition to MLTSS.
9. **Participant Protections:** States must establish safeguards to ensure that participant health and welfare is assured within the MLTSS program, including a statement of participant rights and responsibilities; a critical incident management system with safeguards to prevent abuse, neglect and exploitation; and fair hearing protections including the continuation of services during an appeal.
10. **Quality:** States are expected to maintain the highest level of quality in all MLTSS operations and services through the development and implementation of a comprehensive quality strategy that is integrated with any existing state quality strategies. The design and implementation of a quality improvement strategy must be transparent and appropriately tailored to address the needs of the MLTSS population.

An additional report provided guidance on the timeline for developing such a program. The activities were divided into three phases: (1) plan; (2) implement; (3) refine. Though specific guidance was not provided on the overall duration of this transition, the document does state that stakeholder engagement is essential throughout and that "states report that planning an MLTSS program is challenging and time-consuming."[4]

[4] Truven Health Analytics, “Timeline for Developing a Managed Long Term Services and Supports (MLTSS) Program,” *Truven Analytics*, prepared for CMS, May 2013.

State Examples

Colorado

The State of Colorado began moving Medicaid beneficiaries into Regional Collaborative Care Organizations (RCCOs) in the spring of 2011 as part of its Accountable Care Collaborative (ACC) program. Implemented as a pilot that was limited to 60,000 individuals, the ACC program has grown and, starting in the fall of 2013, the State will begin enrolling dual eligibles into it. Initially, the program includes only acute/medical services, though individuals receiving long-term care services are enrolled. The State has legislation which prohibits the inclusion of LTCSS into managed care entities[5] but is holding stakeholder meetings to explore options and approaches to integrating LTCSS into the ACC program in the future.

New Mexico[6]

Managed care has been the primary service delivery system for Medicaid in New Mexico for more than a decade. The State began its Salud! program (Medicaid managed care) in 1997, managed care for behavioral health in 2005, and its Coordination of Long Term Services (CoLTS) program in 2008. In August 2012, the State submitted a Section 1115 demonstration waiver to create a new, integrated, comprehensive program for its Medicaid enrollees. This program, Centennial Care, is in its implementation phase and will replace all other existing programs and the 12 separate waivers under which the Medicaid program has been operating. Centennial Care managed care plans will provide LTCSS, acute benefits and behavioral health benefits to all Medicaid enrollees.

In moving the LTCSS into Centennial Care, the State is seeking to address short-comings in its current programs and to make the receipt of LTCSS more equitable. The State is proposing to begin taking steps to provide a less complex and more consistent approach to the delivery of LTC services. The State will move forward in phases but as a first step, proposes to implement a policy that will:

- Simplify the LTC service delivery system;
- Make services more equitable;
- Decrease the number of people waiting for needed HCBS;
- Focus the program's limited resources on the most needy people; and
- Provide people the right care at the right time in the right setting.

With changes that will create one comprehensive Community Benefit that includes both personal care and the HCBS formally provided under one of the a 1915(c) HCBS waivers, the State anticipates it will be able to:

- Give more people access to a more extensive array of Community Benefit services that will help keep people out of higher cost nursing homes;
- Reduce the number of people waiting for HCBS by providing needed services – up to the assessed level of need – for anyone on Medicaid meeting a Nursing Facility Level Of Care (NF LOC);
- Move people who are otherwise Medicaid eligible out of HCBS slots, because they will get the same services without using up a slot; and

[5] CRS 25.5-5402.
[6] New Mexico Human Services Department. New Mexico's Centennial Care Waiver Request. Submitted April 25, 2012.

- Control costs by ensuring that serving someone at a NF LOC in the community is less than caring for that same person in a nursing home.

The objective in establishing the Community Benefit is to ensure that eligible recipients do not lose access to needed services especially for those currently enrolled in the Mi Via home and community-based waiver for persons meeting a NF LOC. HSD will ensure continuity of care regarding HCBS for recipients transitioning from an existing waiver to Centennial Care.

Oregon[7]

Like Iowa, Oregon is using an Accountable Care model – through its Coordinated Care Organizations (CCOs) – to transform its delivery of health care. Also like Iowa, they are using a multi-payer approach in that public employees will be included in the CCOs, individuals who are dually eligible for Medicare and Medicaid, and commercially-covered individuals. The Oregon CCOs are community-based entities governed by a partnership of providers of care, community members and entities taking financial risk for the cost of health care. Oregon developed the model over a 3-year period and began enrolling individuals in 2012.

As part of their initial approach, the State has not included LTCSS[8] but is developing an approach to better coordinate these non-CCO services with CCO-services (e.g. primary and preventive care). They are doing this through a shared-accountability system with four primary components:

1. Specific contractual requirements for coordination between CCO and LTCSS systems which were implemented in 2012;
2. Requiring that all CCOs have jointly-developed memoranda of understanding (MOUs) with the local LTCSS field offices in their area that describe clearly defined roles and responsibilities;
3. Reporting and transparency of performance metrics related to better coordination between the two systems; and
4. Incentives and/or penalties linked to performance metrics applied to the CCO and LTCSS system.

Specifically, they are also implementing mechanisms such as:

- Nurse practitioners making rounds to monitor individuals in nursing facilities;
- Use of interdisciplinary care teams and shared care plans;
- Sharing of client-level data between CCOs and LTCSS systems; and
- Bringing health services to individuals in their home or community-based care facility.

In addition, as part of its recent agreement with CMS regarding health system transformation, Oregon agreed to “conduct an exploratory stakeholder process that would result in a report to CMS regarding the integration of Medicaid-funded LTC for the aged or people with disabilities into CCO global budgets.” To accomplish this, the State will engage a small group of stakeholders to begin detailed work designing the system. The work will occur over 4-hour work sessions to be held over the course of six months with final submission to CMS in December 2013.

[7] Oregon Health Authority. https://cco.health.oregon.gov/Pages/Home.aspx
[8] The State is prohibited from including LTCSS in a managed care delivery system.

Tennessee[9]

Tennessee has a long history of Medicaid managed care; starting in 1994 the TennCare program was developed to provide acute care services to all enrollees. Starting in 2010, the State amended its program and included LTCSS into its contracts. Through TennCare CHOICES, approximately 31,200 individuals were enrolled in the TennCare CHOICES program. It is a fully capitated managed care program and beneficiaries receive care from one of three managed care organizations. The MCOs are responsible for all services (primary, acute, behavioral and LTC – including HCBS waiver-type services, personal care visits, attendant care, home-delivered meals, Personal Emergency Reporting System, adult day care, respite, assistive technology, home modifications, and community based residential alternatives.)

There are several LTCSS performance measures in place under the current contract (the State is in the procurement process to select three statewide plans that will begin serving individuals in 2016). Many of these measures are process focused, for example:

- The number and percent of members who have an approved nursing facility level of care eligibility determination prior to enrollment;
- Number and percent of members whose records are reviewed and updated prior to annual review date;
- Number and percent of in-person visits that were on-time.

The rates do include incentives to expand HCBS and there are specific Money Follows the Person (MFP) incentive payments for the MCOs. MCOs receive:

- A one- time payment of $1,000 for successful transition to the community of each MFP demonstration participant up to and including the MCO's established benchmark for the calendar year; and
- A one-time payment of $2,000 upon successful transition to the community of each MFP demonstration participant that exceeds the MCO's established benchmark for the calendar year.

Workgroup Discussion Questions

Goals, Vision and Current State

1. What works well in the existing LTCSS system?
2. What does not work well in the existing LTCSS system?
3. What should be the priorities or goals for the new system?
4. What are the key components of a successful person-centered, integrated, accountable system, particularly for those receiving LTCSS?

Leveraging Existing Structure

5. How should Iowa leverage existing structures? How can we be sure to align this effort with the BIPP and with other initiatives?
6. How do these structures and initiatives potentially need to change to meet Iowa's goals?

ACO Structure and Integration

[9] TennCare. http://www.tn.gov/tenncare/long_choices.shtml

7. If Iowa were to use an ACO model, how would LTCSS be integrated best into that ACO system?
8. What are the potential challenges and barriers to integrating LTCSS within an ACO model?
9. What would be required of the ACO and providers to enhance integration across LTCSS and physical health care services?

Financial and Measurement

10. What measures (i.e. quality and patient satisfaction) should be in place? How should non-health activities such as an increase in the number of individuals with jobs be measured?
11. What type of payment strategies should be considered to reward value-based care for LTCSS and/or transitions from institutional care to home and community based services?
12. If LTCSS are included as a later phase, what types of incentives and shared-savings to existing providers and systems would help coordinate and integrate care in the interim?

IT Systems Needs

13. How would health information technology need to change to support integration?
14. How savvy/sophisticated are the providers with regard to HIE/HIT/EHR and what kind of support will need to be provided to those practices?

Providers, ACOs, and Work Force Concerns

15. Are there adequate numbers of providers available across the state for all services?
16. Where will there be workforce challenges and how can these be addressed?
17. What specific partnerships need to be considered/included or even required?
18. What role should case managers play and what kind of incentives/shared savings activities should or could be used?

Workgroup Suggestions

During the third meeting, the workgroup developed a series of suggestions. The SIM team created a table of these suggestions and emailed the documents to the workgroup members; they prioritized the suggestions to support the SIM team in developing the SHIP. As part of the response to the SIM team, workgroup members also provided comments on the suggestions. To ensure each workgroup was aware of the suggestions generated by other workgroups, all four documents were sent to all the workgroup members.

This following table identifies the category of suggestion and comment; a summary of written comments and priorities received between the third and fourth Workgroup meetings, and the number r of members selecting as a priority (members ranked their top 3 suggestion). **In the final column, green boxes mean three or more people indicated as a priority; yellow boxes mean two people indicated as a priority; purple boxes mean one person indicated as a priority; and white boxes mean no member prioritized that suggestion.** It should be noted that not all workgroup members provided an indication of their priorities.

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
Coordination	1	Care coordination needs to be a function that is not tied to a specific set of benefits. There needs to be a solid definition of care coordination that is in alignment with national definitions and is adopted throughout Iowa. The definition should focus on the functions of care coordination, rather than the process, and ACOs need to be held accountable for the functions and the outcomes, while allowing for flexibility in the processes they develop.	1) Right now too few people receive it and, as stated by an individual that has been supporting and utilizing care coordination for many years, this is one of the best answers to improved outcomes and support to the patient. 2) Comprehensive coordination across all services needed is essential to ensure appropriate services provided at the right time and place. 3) The State should set forth specific outcomes and then enable ACOs through the RFP process to address how they will achieve those outcomes. If there are specific populations that require outreach, ACOs should be required to provide an outreach strategy or plan. By enabling outcomes, ACOs will be able to demonstrate programming innovation and showcase regional partnerships.	
Coordination	2	There needs to be a primary care point of contact for all care	The State should set forth specific outcomes and then enable ACOs through the RFP process to address how they will	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
		coordination activities (not multiple coordinators)	achieve those outcomes. If there are specific populations that require outreach, ACOs should be required to provide an outreach strategy or plan. By enabling outcomes, ACOs will be able to demonstrate programming innovation and showcase regional partnerships	
Coordination/ Financing	3	There needs to be financing/payment for the care coordination function		
Communication	4	There needs to be a form of communication that is easily understood for patients (this means there should be written instruction that includes specific data elements but not too much information)		
Communication/ Technology	5	Technology needs to support communication across providers		
Communication/ Coordination	6	HIPPA is a barrier – change at the federal level are needed		
Communication/ Coordination (Technology)	7	There should be financial support and training for LTC providers to gain access to EHR. Providers need access to real-time data to support communication and coordination		
Access	8	The State's contracts with the ACOs should include language that ensures sufficient capacity of LTCSS for the population being served.	It is likely that the ACO will utilize existing providers.	
Access	9	The ACO model should support the use of the telemedicine and telemonitoring to address access issues		
Access	10	The State should require that the ACOs demonstrate capacity at a rural level and provide a plan of support to help providers adjust to	The specific partnerships will vary by region, by readiness and by resources available within the geographic locations.	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
		the ACO model		
Patient Engagement	11	As part of supporting compliance with care and treatment plans there should be patient incentives/ rewards at the point of care	1) Patients will respond particularly well to financial incentives and without engagement the best systems will fail. This is a key component to success in changing behaviors. 2) At a minimum, the State should seek waiver authority similar to those recognized by the MSSP fraud and abuse waivers. The State should seek similar waiver protections for all five MSSP waiver categories (ACO Pre-Participation, ACO Participation, Shared Savings Distribution, Compliance with the Physician Self-Referral Law, and Patient Incentives). For patent incentives, ACOs should be permitted to secure waivers for incentives that encourage preventive care and compliance with treatment regimes	
Patient Support	12	The ACOs should be required to have a Medication Reconciliation program		
Patient (Family) Support	13	There needs to be a focus on and support for families when children transition from the children's system to the adult system		
Measures	14	There should be one Core Set of quality care measures that all ACOs use	ACOs are fundamentally different than MCOs. ACO care coordination does not equate to a third-party administrator with a focus on utilization and referral management. ACOs are provider-led organizations that deliver innovative programming to effectuate quality and efficiency improvements. For member engagement, infrastructure investments may include IT, after-hours capabilities, health literacy and motivational interviewing training, and regulatory training regarding incentives. Investments by ACO in overall infrastructure and programming are expected to occur while simultaneously reducing costs. While the State has mentioned the potential for up-side only	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
			shared savings, this funding mechanism does not recognize the immediate need for programming infrastructure. For the initial two years, the State to should establish a care coordination fee for ACOs willing to enter into a long-term at–risk contract.	
Measures	15	There should be an additional metric that measures increased use of home and community based services/how well people are connecting with HCBS	The State should seek to utilize a few existing measures in reporting systems (Such as HomeHealth Compare in Home Care, MDS in Long Term Care or Public Health reporting) in such a manner that emphasis is placed on the specific metrics most likely to decrease cost and improve outcome.	
Regulatory	16	There need to be changes to the Adult Day Services regulations		
Regulatory	17	The State should seek ways to un-complicate the delivery of waiver services. Waivers should be simplified and streamlined. (*SIM team note: while only one work group member prioritized this in the feedback submitted by email, this recommendation was discussed at length in the last work group meeting and many work group members expressed support for it).*	1) The State should consider gradually consolidating waivers 2) The regulations need to be aligned with the intent of the change to the existing system. Without regulatory changes the State (and the health care system) will continue to struggle to make the new system fit into the old regulatory system (round peg in a square hole). 3) When discussing waiver services intentions, were geared toward fraud & abuse waivers.	
Patient/Provider Support	18	There should be a state-wide support line that provides information on LTCSS services/providers/options for providers and families (*SIM team note: this is likely addressed in the BIPP initiative)*		
Provider Support	19	There need to be educational programs to train care coordinators/make sure that care coordinators are skilled in and aware of social supports.	1) There needs to be educational programs to train care coordinators and make sure they are skilled in and aware of social supports. There should be an on-line training for care coordinators to develop core competencies that will help them understand what is expected and required of them.	

Category	#	Suggestions Captured from Workgroup Meetings	Summary of Members' Written Comments on Suggestions	Number of Members Selecting as Priority
			2) Based on extensive review of the literature on care coordination, there are many different definitions and pieces of care coordination. The State needs to answer questions such as: Which ones are the most important and will be required? What do care coordinators need to do to help the system thrive and ensure patients succeed in improving their health care status? 3) It is insufficient to say there will be care coordination; education and support must be provided to care coordinators to insure success. 4) It should be noted that the cost and investment required by ACOs to develop material, train staff and hard wire health literacy behaviors is very expensive and labor intensive. Consideration of the investment by the ACO needs to be incorporated into the financial modeling.	
Provider Support	20	There need to be educational programs to train care coordinators/make sure that care coordinators are skilled in and aware of chronic disease management techniques (for example the Stanford Model)	It should be noted that the cost and investment required by ACOs to develop material, train staff and hard wire health literacy behaviors is very expensive and labor intensive. Consideration of the investment by the ACO needs to be incorporated into the financial modeling.	
Community Focus	21	Public health should help educate Iowans to support vulnerable populations in the community (for example, help mailman and others identify individuals in need of support)		

Additional Suggestions Received Outside of Workgroup Meetings
There was support for the idea of a Transformation Center, which should include opportunities for individuals/clients/consumers to provide input and also learn about the ways that the health care system is transforming.
ACOs should be held accountable for outcomes, but have flexibility in process.
There was support for the idea of a “Community Reinvestment Fund” to be funded from a small percentage of savings.

Additional Suggestions Received Outside of Workgroup Meetings
There is a need to have some work done to streamline regulations that hinder care coordination. This could be a task of a Transformation Center – to study the regulations and make recommendations for simplifying and streamlining the regulations.
There should be work done to address workforce shortages that are likely to become more problematic in upcoming years. There is opportunity to link with public health's efforts on this.
ACOs should develop and implement plans for medication management to be provided as part of care coordination.

Sources

Centers for Medicare and Medicaid Services. “Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs,” *Centers for Medicare and Medicaid Services*, May 20, 2013.

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